ethical committees should draw on both clinical and non-clinical disciplines for their membership. The committees cannot hope to evaluate the scientific merits of research without the benefit of informed opinion. Without an adequate evaluation, the ethical may be excluded and the unethical slip through. But the committees would be hopelessly unwieldy if all possible disciplines and grades were represented. This might suggest some kind of division into constituencies which could nominate representatives. However, secondly, where a discipline is not represented directly it is important that the investigator be allowed to present his case in person and that a representative of that discipline who is fully conversant with the investigator's approach should join with the ethical committee and participate fully in the discussions which precede their decision.

The effective operation of ethical committees depends upon the consent of those they are set up to monitor. That consent cannot be imposed or demanded. It can only be acquired if the committee's decisions and justifications are seen to be fair, just and reasonable, based on a full and informed consideration of all the issues involved. Such confidence will be most readily accorded to a broadly representative committee with open procedures and a readiness to accept the diversity of scientific investigation.

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Active and passive euthanasia

SIR,

Dr Richard Nicholson in his article, 'Should the patient be allowed to die?' writes: 'Euthanasia, literally a "well, or good death", may be voluntary or involuntary; it may also be either active or passive, these terms in practice being used synonymously with positive or negative euthanasia. Active, or positive, euthanasia involves the use of treatments designed to promote death sooner than would otherwise be expected. Passive, or negative, euthanasia is a failure to use therapies that would prolong life in a patient with a terminal illness.'

We are writing to you jointly, one of us a supporter and the other an opponent of legalized voluntary euthanasia, in the hope of checking the spread of the expression 'passive euthanasia'. In this and other English-speaking countries the established usage of 'voluntary euthanasia' refers only and precisely to what Nicholson calls *active* voluntary euthanasia. Furthermore, 'good terminal care', which Nicholson regards as synonymous with passive euthanasia, is anything but passive or negative.

The effect of introducing his distinction must be harmfully divisive. If the avoidance of 'furor therapeutica' comes to be thought of as a form of euthanasia, then those who are against euthanasia will be inclined to support 'furor therapeutica'. This is a result which both the present writers, and Nicholson too, would deplore.

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Dialogue between Marshall Marinker and Ivan Illich

SIR,

As a lawyer surreptitiously present at the London Medical Group conference on iatrogenic disease, I was aware of partaking in a function not only of medical significance, but of a deeper philosophical, even theological, importance. The real dialogue of the day seemed to me to be between Marshall Marinker and Ivan Illich.

Illich I was prepared to be disappointed in or impressed with. Marinker I did not know of. Both their contributions were articulate and compelling, and I was impressed with both. But it is only through the benefit of time for thought that I have identified, for myself at least, the area in which they are unable to meet. It is the area of priesthood.

Illich articulated the concept of the area of man's autonomous self control. As he was talking of medicine he was constantly in fear of appearing to glorify the miseries of human suffering. He carefully picked his way through the dangers of holding a brief for the ultimate value of human responsibility, whether for your bank balance or your death.

Marinker seemed to me the almost perfect apostle of enlightened contemporary society. He was concerned to justify historically what he called 'the clinical transaction'. The ghastliness of the term did not deter me from the intellectual substance of his position. He saw the doctor as something more than a mere technician: he saw him as the senior partner in an almost metaphysical relationship.

Now it is that point that identified for me, at least, the reason why Illich caused a greater spiritual empathy. Man does need to be cared for and to believe, but it is not the doctor but the priest who has traditionally fulfilled this role. Marinker was wrong when he said: 'History suggests that the fact of the dialogue will not be changed'. Even his delightful reference to the historical Ivan Ilyich betrays the point. This man's question whether his condition is 'dangerous or not?' does not indicate a man seeking a personal spiritual relationship. On the contrary, he is a man seeking information about the physical parameters of his existence. Certainly there is no indication from the reply of the doctor – 'mind your own business' – that he is aware of this need for a relationship. On the contrary he is aware of a purely technical superiority, independent of any transcendental spiritual communication. The Ivan Ilyich of history on hearing that his condition was fatal would be far more likely to satisfy his economic commitment to the doctor and then seek the priest for the arrangement of his deeper spiritual relationships.

As I understand Illich – and I don't pretend he is easy to understand – he is trying to assert the value of man breaking free from the institutionalized provision of his